Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: NORTHWEST TEXAS HOSPITAL 1201 LAKE WOODLANDS #4024 WOODLANDS TX 77380	MFDR Tracking #: M4-10-4333-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO Box #: 54	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Received EOB from Tx Mutual for payment $148.36 on the $2363.92 charge. We pulled UB & figured the reimbursement to be at least $876.90. We have been underpaid at least $728.54. Per EOB on 893 code – "This code is invalid". CPT Book & fee schedule code shows to be active & payable. Received information from Theresa: that code 97110 is a good code. We sent appeal to Tx Mutual for additional Payment. Appeal has been denied."

Amount in Dispute: $271.34

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Response not received

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
08/03/09, 08/05/09, 08/07/09	Outpatient Physical Therapy – CPT Code G0283GP	(53.68 ÷ 36.0666) x $11.00 = $16.37 x 3 units = $49.11 - $49.11 (carrier payment)	$18.57	$0.00
08/11/09	Outpatient Physical Therapy – CPT Code 64550GP	(53.68 ÷ 36.0666) x $8.46 = $12.59 x 1 unit = $12.59 - $15.81 (carrier payment)	$12.91	$0.00
08/03/09, 08/05/09, 08/07/09. 08/11/09	Outpatient Physical Therapy – CPT Code 97010GP	N/A	$205.30	$0.00
08/03/09, 08/11/09	Outpatient Physical Therapy – CPT Code 97535GP	(53.68 ÷ 36.0666) x $28.03 = $41.71 x 2 units = $83.44 - $83.44 (carrier payment)	$34.56	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for hospital outpatient services.

This request for medical fee dispute resolution was received by the Division on June 21, 2010.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - CAC-B18 – This procedure code and modifier were invalid o the date of service.
   - CAC-W1 – Workers Compensation State Fee Schedule adjustment.
   - CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudication.
   - 284 – No allowance was recommended as this procedure has a Medicare status of "B" (Bundled).
   - 494 – Hospital Outpatient allowance was calculated to Medicare's Methodology plus a markup per the Texas Fee Schedule.
   - 893 – This code is invalid, not covered code or has been deleted from the Texas Fee Schedule.
   - 891 – The insurance company is reducing or denying payment after reconsideration.
   - CAC-W4 – No additional reimbursement allowed after review of appeal/reconsideration.
   - 420 – Supplemental Payment
2. Division rule at 28 TAC §134.403(h) states that for medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.
3. The disputed services are CPT Codes G0283-GP, 64550-GP, and 97535-GP. According to Medicare, hospital outpatient physical therapy services are Status A codes. Status A codes are paid under a fee schedule or with a prospectively pre-determined rate. In accordance with 28 TAC Section §134.203, the division concludes that the Requestor has been correctly reimbursed for these procedures and no additional reimbursement is recommended.
4. CPT Code 97010 is considered a Status B code. Status B codes are considered by Medicare policies to be bundled procedures and are not separately reimbursable. As a result no additional reimbursement is recommended.
5. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:
   (1) No documentation was found to support a contractual agreement between the parties to this dispute; and
   (2) MAR can be established for these services.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code §413.031©, the Division concludes that the requestor is not due additional payment. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.305, §133.307, §134.203, §134.403
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	March 4, 2011 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.